TARGET Pharmacy

AUTHORIZATION FOR RELEASE OF RECORDS

I authorize Target Pharmacy at my request to release my prescription profile to the individual identified below. I understand I can revoke this authorization at any time prior to its expiration, which unless otherwise indicated will be six (6) months from my execution of this authorization. In order to revoke this authorization, I must submit a written revocation to my local Target Pharmacy, and I understand that the revocation will be valid from the date received by the pharmacy, except to the extent the pharmacy has already taken action in reliance on this authorization. I understand that Target Pharmacy cannot refuse to fill my prescriptions based on whether I sign this authorization. I understand the information disclosed could be subject to redisclosure by the person receiving records as identified below, and no longer protected by federal privacy regulations. I have retained a copy of this authorization for my records.

Print Patient Name: _____ Date of Birth: _____

Dates of Records Request:

Start Date:_____ End Date:_____

Name and Mailing Address of Individual to Receive Records

_____

_____

_____

Patient Signature: _____ Today's Date: _____

CERTIFICATION

If you are requesting records of another person who is unable to sign this authorization, complete the top part of this form with the information of the person whose records you are requesting. You must also certify your authority to act as follows:

I hereby certify that I am authorized to act for the individual whose records are to be released pursuant to this authorization. My authorization to act for this individual is derived from (check applicable statements):

- ☐ Health Care Power of Attorney
- ☐ Legal Guardian
- ☐ Personal Representative
- ☐ Other (describe):_____

Sign Your Name: _____ Today's Date: _____

Target reserves the right to exercise its discretion in releasing the records of any individual to you.